FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Colorado
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) Child Health Plan *Plus* (CHP+)

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
__X__ Separate SCHIP Program Only
____ Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date_____

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC: for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility -- NC

2. Enrollment process -- NC

3. Presumptive eligibility -- NC

4. Continuous eligibility -- NC

5. Outreach/marketing campaigns
   - Partnered with 4 of 6 Managed Care Organizations for media buys from April-June 2000: Resulted in 10% of the applications received through that time period
   - Piloted Direct Mail Campaign in August: Did not result in significant numbers of new enrollments, and was terminated in October
   - Worked with Managed Care Organization partners to refine retention efforts
   - Increased the type and number of Satellite Eligibility Determination (SED) sites around the state, throughout the year
   - Created SED Site Incentive program, which occurred throughout the summer
   - Revised National School Lunch Program check-off box on application to prompt only families not enrolled in a current program
   - Established new three-step process to increase retention: 1) send postcard, alerting family to forthcoming enrollment packet; 2) send enrollment packet (includes application, instructions & postage-paid addressed envelope); 3) send follow-up postcard & make phone calls to those who haven't submitted their renewal applications
   - Currently, paying Colorado School Medicaid Consortium and Jefferson County School District (largest in the state) to expand S-CHIP outreach into schools.
   - Currently, encouraging community health centers to enroll all eligible and willing state medically indigent care program children (Colorado Indigent Care Program, or CICP) into S-CHIP

during "premium holiday" period *(See #9 below.)*

6. Eligibility determination process -- The number of satellite eligibility determination sites (SEDs) around the state has increased from 65 to 83.

7. Eligibility redetermination process -- NC

8. Benefit structure -- NC

9. Cost-sharing policies: The Governor instituted a "premium holiday" from September-December 2000; forgave of all current S-CHIP families any past debt accrued; and recommended annual enrollment fees of $25 for families with one S-CHIP child and $35 for families with two or more S-CHIP children. This increased the number of applications to the S-CHIP program, in September and October 2000, by 50% over the previous year for the same time period. The Children's Basic Health Plan Policy Board enacted these changes in November 2000, to go into effect January 1, 2001.

10. Crowd-out policies -- NC

11. Delivery system -- NC

12. Coordination with other programs (especially private insurance and Medicaid) -- NC

13. Screen and enroll process -- NC

14. Application -- The Department designed a joint S-CHIP/ Medicaid application early in the program's development. This application responded to the federal requirement that S-CHIP screen for Medicaid to facilitate referral between the programs. In SFY 2000, the Department significantly reduced the documentation requirements associated with the joint S-CHIP/Medicaid application, so that the only documentation needed to accompany the application was the verification of the family's income for the prior month.

    In SFY 2000, applications could be filed on-line from 11 locations statewide as part of an initial electronic development project. This on-line filing system will be phased-in across the state over time. Recently, Colorado's S-CHIP expanded its pilot project, of having SED sites file applications electronically, to 22 locations. Sites are typically community-based organizations that provide services to the low-income population, but they are outside of the conventional human-service environment. The original objective of the sites was to provide a familiar local setting where families could receive information about and apply for the S-CHIP program at the same time they are receiving other services. This is commonly referred to as the "teachable moment," since it is when people are most aware of their need for additional services.

Currently, Colorado's S-CHIP has a network of 83 SED sites statewide, including multiple locations for one site. These sites comprise community health centers, county nursing services, school-based health centers and other community providers.

Finally, SFY 2000 represents a turning point regarding the joint application form itself. The Department, in collaboration with the Department of Human Services, Covering Kids Colorado, Child Health Advocates, Colorado Community Health Network, local county departments of social services, and SED sites, applied for and received a grant from the Rose Community Foundation to redesign the joint S-CHIP/Medicaid application. The Joint Application Redesign Committee contracted with a professional designer and a marketing firm to develop a form that incorporates the most current application concepts and evaluates those concepts through client-centered focus groups. The new application becomes available to families, providing a simpler format and better guidance for applicants to follow, by January 1, 2001.

15. Other -- NC

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

   Colorado currently is re-assessing its estimate of the state's low-income uninsured, and will be considering new data from the Urban Institute, as well as Census data, in making its judgments in SFY 2001. The new Urban Institute data, expected by the middle of calendar year 2001, will provide estimates that reflect Colorado's eligibility requirements. Specifically, they are expected to provide more realistic estimates of the uninsured and of S-CHIP-eligibles for Colorado than have been available previously. The State's revised estimate of uninsured should be complete and reported in the next annual report. Currently, the estimate remains the same as that reported in the March 2000 Evaluation (69,157 CHIP-eligibles).

   Colorado's S-CHIP program estimates that approximately 38% of its estimated S-CHIP-eligibles were enrolled as of September 30, 2000. This is based on an enrollment of 26,030 for September. When considering the proportion of children *ever* enrolled in S-CHIP for the FFY 2000, there have been 34,889, or approximately 50% of the state's S-CHIP-eligibles, enrolled at some time during the year. Because of the mobility of this population in and out of public programs, as well as in and out of the state, a number of factors may explain this difference between enrollment on September 30 and enrollment over the year. Some families may have obtained access to employer-based insurance; some may have moved to

Medicaid; and some may have left for naturally-occurring reasons, such as aging-out of the Program, changes in income, or changes in residence.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   The State and its administrative services contractor currently are coordinating efforts with Covering Kids of Colorado and with Medicaid to obtain this information. A process should be fully defined in early calendar year 2001.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

   See Sec. 1.1 - #5, 1.4, and Sec. 2.4, for outreach efforts; and Sec. 1.6 for information on surveys of disenrollees -- why they leave the program and how they get health care after leaving S-CHIP.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   __X__ No, skip to 1.3

   ____ Yes, what is the new baseline?

   What are the data source(s) and methodology used to make this estimate?

   What was the justification for adopting a different methodology?

   What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

   Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as

specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1. Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care coverage	1a) Decrease in the proportion of children ≤ 185% FPL who are uninsured by 50%	Data Sources: Under age 19 population estimates for 2000 by the Colorado Demography Information Service; county uninsured rates from 1997 Colorado Health Source Book, using 1995-97 CPS data; American Academy of Pediatrics' estimate of proportion of S-CHIP-eligibles in the under age 19 uninsured population (using 1994-1997 CPS data). Methodology: The program's baseline was calculated using the Colorado Demography Information Service's estimate of the under-19 population for each county in Colorado, for the year 2000 (based on historical data and estimates of population growth rate). Then county uninsured estimates from the 1997 Colorado Health Source Book (using an average of 1995-1997 CPS data) were applied to each county's projection. With AAP's estimate of the proportion of S-CHIP-eligibles among the uninsured (based on an average of 1994-1997 CPS data), 40.1% of the uninsured under age 19 were computed for each county, and summed for a state total. This resulted in 69,157 uninsured children under age 19 and eligible for S-CHIP. This estimate currently is being reviewed, but as yet has not changed. Numerator: FFY 1999, year-end total 21,289; FFY 2000 year-end total 26,030 Denominator: (FFY 1999 and FFY 2000) 69,157 est. eligibles Progress Summary: By the end of FFY 2000, comprehensive health care coverage was being given to 26,030 children who previously did not have access to affordable health insurance, or 37.6% of the estimated uninsured. This constitutes attaining 75.3% of the State's goal for reducing, by 50%, the number of uninsured children at or below 185% FPL, after only two-and-one-half years of operation.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	1b) Increase the percentage of uninsured children enrolled in the Children's Basic Health Plan, dba Child Health Plan Plus (CHP+) as compared to market penetration for the Colorado Child Health Plan [existing prior to CHP+ and Title XXI]	Data Sources: S-CHIP administrative data comparing enrollment in CHP+ with enrollment in CCHP, as a percentage of the number of uninsured children Methodology: Computation of 2000 year-end CHP+ and April 1998 CCHP enrollment totals divided by number of S-CHIP eligibles (CCHP did not operate in FY 2000). April 1998 was the initial month of S-CHIP operation, so CCHP was at its peak that month. Numerator: 14,086 (CCHP); 26,030 (S-CHIP, or CHP+) Denominator: 69,157 (both) Progress Summary: The percentage of uninsured children at or below 185% FPL enrolled in the pre-existing, outpatient-only CCHP program was 20.4% as of April, 1998. The percentage of uninsured children in the same income range who became enrolled in S-CHIP as of FY 2000 year's end was 37.6%, representing an 84.3% increase in market penetration over CCHP.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
		Data Sources:

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
2. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children	2a) Enroll 66% of children currently receiving benefits through the outpatient Colorado Child Health Plan into the comprehensive Child Health Plan Plus by July 1, 1998 2b) Enroll 50% of children who previously received services through the Colorado Indigent Care Program into the Child Health Plan Plus by July 1, 1999. 2c) Maintain that 50% of	Data Sources: Administrative data Methodology: Using the final enrollment total for the outpatient CCHP program, as of the last date of enrollment — 3/15/98 — or 14,086 enrollment as of 4/1/98, 66% of that total was computed (9,297). Then the total July 1, 1999, enrollment in the Title XXI CHP+ program (6,862) was found in administrative monthly enrollment data, using the updated SFY year-end report run 9/13/98. Numerator: 2a) 6,862; 2b) 17,929; 2c) unknown; 3a) 29 Denominator: 2a) 14,086; 2b) unknown; 2c) approx. 550/mo.; 3a) 63 Progress Summary: 2a) As reported in the March 2000 Evaluation, by July 1, 1998, 48.7% of the children who were receiving benefits from the outpatient CCHP program, during its final month, had been enrolled into the Title XXI CHP+ program. It is not known how many additional CCHP families chose to enroll their children in CHP+ at a later time, after some lapse in coverage, thus increasing the proportion of CCHP enrollees who chose to enroll in CHP+. 2b) As reported in the March 2000 Evaluation, the Colorado Indigent Care Program (CICP), reimbursing partial cost of treating uninsured families under 185% FPL, does not maintain an eligibility system, only a claims payment system. Colorado is working

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	referrals from CHP+ to Medicaid enroll in Medicaid.	with both CICP and the Colorado Medicaid program to develop a common eligibility system that would allow tracking of enrollees. This is not expected to start becoming operational until July 2002.
3. Acquire contracts to provide statewide coverage	3a) Secure HMO coverage by one or more HMOs in each of the 63 Colorado counties	2c) See 2b, above. 3a) Progress Summary: The authorizing legislation for the CHP+ program requires that health care services be delivered to CHP+ enrollees through Medicaid managed care organizations wherever possible. Fifty-nine percent (59%) or thirty-seven (37) of Colorado's counties offer HMO coverage by one or more HMOs. Since the last reporting, HMO coverage has expanded to eight (8) counties, representing a thirteen percent (13%) increase in the number of counties with HMO coverage. Since HMO coverage is offered in the majority of the metropolitan areas in Colorado, 86% of eligibles have access to HMO coverage. There are plans for 12 additional counties to be covered by HMOs effective July 1, 2001. HMO coverage is not available in some rural counties. In those areas, CHP+ provides comprehensive benefits to enrollees through a non-HMO managed care delivery system. Since these 26 counties include the mostly rural areas of the state, it can be said that only 14% of all CHP+ eligibles do not have access to HMO coverage.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
4. Improve health status of children in Colorado with a focus on preventive and early primary treatment	4a. Ninety percent (90%) of S-CHIP enrolled children under two years old receive basic immunization series	Data Sources: N/C Methodology: N/C Progress Summary: In January 2001, Colorado's SCHIP will receive its first utilization

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	4b. Ninety percent (90%) of 13-year-olds receive required immunizations 4c. Seventy-five percent (75%) of children under 15 months receive recommended number of well-child visits 4d. Seventy-five percent (75%) of three, four, five, and six-year-olds receive at least one well-child visit during the year 4e. Seventy-five percent (75%) of children 12 through 17 receive at least one well-care visit during the year.	data from its contracted HMOs for State Fiscal Year 1999-2000. This data will be used as a baseline for utilization in CHP+. Colorado is continuing to explore its options for gathering other quality data, including HEDIS measures, in order to meet its objectives.
OTHER OBJECTIVES		
5. Do not "crowd out" employer coverage	5a. Maintain the proportion of children ≤ 185% FPL who are covered under an employer-based plan, taking	Data Sources: N/C Methodology: N/C

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	into account decreases due to increasing health care costs or a downturn in the economy	Progress Summary: N/C

OTHER OBJECTIVES		
5. Do not "crowd out" employer coverage	5a. Maintain the proportion of children ≤ 185% FPL who are covered under an employer-based plan, taking into account decreases due to increasing health care costs or a downturn in the economy	Data Sources: N/C Methodology: N/C Progress Summary: N/C

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

See Table 1.3, performance goals 1a, 2b, 2c, 3a, and 4. Last year's disenrollment and re-enrollee surveys, administered by Sundel Research (*See last year's March 2000 Evaluation*), indicated that communication of renewal procedures, as well as the application requirements, were barriers to retention. Several strategies have been implemented to address these problems *(See Sec. 3.1 -- #4, following)*. In addition, callers for the Sundel Disenrollee Survey *(See Sec. 1.6)* take the opportunity, when talking with families, to re-iterate renewal policies and other changes to policy, such as the new annual enrollment fee, to ensure that these messages are getting out.

CICP Study: The Department is conducting a study of the feasibility of transferring eligible children from the sliding-scale, pay-as-you-go Medically Indigent program (Colorado Indigent Care Program, or CICP) into managed care coverage through the S-CHIP program. Attached is the report from this study. *(See Attachment A : "Eliminating Children from the Medically Indigent Program and Enrolling Them into the Children's Basic Health Plan: Issues and Recommendations," by Barbara Yondorf, September 2000.)*

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Survey of Disenrollee Families: Colorado's S-CHIP program recently hired an independent contractor to conduct a survey of disenrollee families to determine characteristics of enrollees and their reasons for disenrollment. The study conducted by Sundel Research, Inc., is very similar to a study conducted by Sundel for the State a year ago, but with several changes: 1) a larger, four-month sample of disenrollees, rather than only a one-month sample; 2) the addition of specific questions on the kind of health care coverage disenrollees are obtaining after leaving S-CHIP, versus whether they are becoming uninsured;
3) questions to determine families' awareness of the annual renewal policy; and 4) the provision of a Spanish-speaking interviewer, so that Spanish-speaking families can respond to the survey. This survey is being conducted using September through December 2000 disenrollees, and will be analyzed in January and February 2001. A sample and response rate, larger than those obtained in the first disenrollee survey, are expected

The first disenrollee study, conducted by Sundel a year ago, indicated that 79% of disenrollees left the program because they obtained other health insurance. The State will be comparing the results of the current study with the results from the former one to verify this

finding with the larger sample, as well as similar findings from other studies.

Study of Satellite Eligibility Determination Sites (SEDs): Beginning in February 2001, the State will conduct a study of SED site operations, examining workload, efficiency, and impact, compared with other methods of S-CHIP outreach, such as mail applications. There are 83 sites around the state that will be submitting monthly reports over a four-month period. Combined with administrative data on these sites, an evaluation of their cost-effectiveness and success of operations is expected to provide an overview of effectiveness. Data collection will continue until May 31, 2001, and the report will be complete by June 30, 2001.

Survey of Re-Enrollee Families: Allison Kempe, M.D., of The Children's Hospital, is conducting a follow-up survey of families who allowed their child's S-CHIP coverage to lapse and then returned to the program as re-enrollees. These families were surveyed a year ago, and current follow-up surveys focus on elements of satisfaction, health care, and health status. This follow-up phase of the study began in September and data collection was complete, as of November 2000. The report should be finished by Spring 2001.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

(See last year's March 2000 Evaluation. Studies begun in late FFY 2000 will be included in the FFY 2001 annual report.)

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N/A

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

N/A

Number of adults_____
Number of children_____

3. How do you monitor cost-effectiveness of family coverage?
   N/A

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

   Colorado is exploring options to provide subsidized coverage to S-CHIP-eligible children through an employer buy-in program *(See Attachment B: "The Children's Basic Health Plan Premium Assistance Program Feasibility Study: A Proposal to the Rose Community Foundation from the Colorado Medical Society Foundation, by Sarah Schulte and Barbara Yondorf).* The Program has applied for grant funding, and the proposal is pending. The Department does not consider it feasible at this time to manage employer-buy-in arrangements.

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   N/A

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

The enabling legislation for Colorado's S-CHIP program mandated that enrollees in S-CHIP cannot have had comprehensive health care coverage for at least three months prior to enrollment in the program. This question is asked of every applicant. It then can be assumed that the total number of enrollees in Colorado's program have not caused "crowd-out" of employer-based coverage.

1. How do you define crowd-out in your SCHIP program?

2. How do you monitor and measure whether crowd-out is occurring?

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method

used to derive this information.

(See above, under 2.3.)

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

- Colorado's S-CHIP measures effectiveness through three mechanisms: 1) an application number tracking system; 2) call center statistics; and 3) surveys. These data are utilized against estimated eligibles by population sector (age, ethnicity, urban/rural, county, etc.) The application tracking system is flexible enough to inform exactly where an applicant has heard of S-CHIP and/or received an application. Consistently, more than 55% of S-CHIP applications are received through the mail. The top five sources of referral for applications through the mail are family/friend; brochure; TV; National School Lunch Program and doctor's office. The next highest source of applications is the Satellite Eligibility Determination (SED) sites (about 25%). Finally, the County Departments of Human Services (local Medicaid determination offices) provide about 20% of the applications. Perpetuating word of mouth and TV advertising have been very effective tools, in addition to supporting community partners. The call center statistics indicate increased calls after certain TV shows around which the program has placed ad buys -- for example, "COPS" and "Leeza." No surveys on market penetration were administered this year.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

- Colorado's S-CHIP program has just granted more than $350,000 to 28 community partners for various outreach projects. Some are focused on specific target groups, such as minorities and Immigrants. Because this project has just begun, specific information is unavailable at this time. In addition, the program has experienced tremendous success in rural areas because of the precursor program, the Colorado Child Health Plan (CCHP), which operated only in rural areas. Many counties in the state have enrolled 100% of the estimated eligible children.

3. Which methods best reached which populations? How have you measured effectiveness?

- Community Health Centers and Hospitals, for all families who use health services
- TV, for all families
- Schools, for all families

Effectiveness is measured by the source of the applications sent to S-CHIP.

2.5 Retention:

1. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

____Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population _____
____ Information campaigns
____ Simplification of re-enrollment process, please describe _____
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe An exit survey is conducted monthly. Other, more extensive, one-time surveys are discussed in Sections 1.4 , 1.7 & 2.5.
____ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

   The Sundel study on disenrollees, described in Section 1.6, will provide information on insurance coverage of disenrollees subsequent to S-CHIP enrollment.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

   Colorado uses a joint application form for the S-CHIP program and the children's and families Medicaid programs and requires the same income documentation for these programs.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

   Medicaid to SCHIP: When the county department of social services determines that an

applicant is not eligible for Medicaid, for reasons of over income or over assets, the county staffs forward a copy of the denial letter and the application to the central S-CHIP contractor.

SCHIP to Medicaid: When the central S-CHIP contractor determines that an applicant is not eligible for S-CHIP, due to probable eligibility for Medicaid, the central S-CHIP contractor completes a coverpage for the application explaining the reasons why the central contractor believes that the applicant is eligible for Medicaid, and attaches this explanation to the application. If the applicant is eligible for Medicaid, the county will complete and return the coverpage, indicating that the applicant is eligible. If the applicant is ineligible for Medicaid, the county will complete and return the coverpage and attach a copy of the Medicaid denial letter.

The application has been designed to be complete for both systems. There are no follow-up "appointments." Either system can process the application if it is complete.

Eligibility records are maintained in separate information systems for S-CHIP and Medicaid. When an eligible S-CHIP child is identified as having Medicaid coverage, the child is immediately disenrolled from S-CHIP. If the child is in an S-CHIP HMO, he or she is moved to that HMO's Medicaid product, with no disruption in enrollment or change in provider. If the child is enrolled in the non-HMO S-CHIP managed care system, his or her provider is contractually obligated to bill Medicaid and accept Medicaid reimbursement until transition to another provider (if necessary) can be accomplished.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

The networks maintained by HMOs for both S-CHIP and Medicaid are identical. There is significant overlap between physicians participating in the Medicaid program and in the S-CHIP, non-HMO delivery system, but continuity of care is always maintained if a transition is necessary.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

(Please see Attachment C: "Children's Basic Health Plan Cost-Sharing: Department of Health Care Policy and Financing Position Paper," September 22, 2000.)

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? No. If so, what have you found?

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

   Colorado currently does not have available data on the quality of care received by SCHIP enrollees. We have access to the Medicaid quality assessments for the same network, however, and we are beginning to collect utilization data.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

   Colorado plans to implement HEDIS measures to monitor and assess the quality of care received by SCHIP enrollees in FY 2002.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

   Colorado will receive its first utilization reporting in January 2001 for the State Fiscal Year 1999 - 2000. This data will be used to form baseline measures of utilization for its SCHIP enrollees. Colorado is continuing to develop its long-term quality plan, including HEDIS measures, which are expected to be collected in 2002 for the 2001 plan year.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility -- Colorado's first formal S-CHIP eligibility rule was implemented December 1, 1999, promulgated on a legal analysis of the state statute implementing CBHP that required eligibility determination be based on gross family income, without any income disallowances. This rule was a significant change to previous eligibility guidelines and caused some families to no longer qualify for the program. The new standard meant three separate eligibility requirements for low-income children: Medicaid, S-CHIP and the Colorado Indigent Care Program. Recognizing this to be a barrier to enrolling children, the General Assembly revised state statute during its SFY 2000 legislative session. S-CHIP then developed a new eligibility rule that mirrors the one in place for the Colorado Indigent Care Program (except in cases where federal law mandates otherwise). The new rule allows families who were previously eligible for the program, but were denied coverage under the last rule, to be eligible again for the program. The new eligibility process enacted by this rule became effective October 1, 2000.

   In SFY 2000, the Department significantly reduced the documentation requirements associated with the joint CBHP/Medicaid application, so that the only documentation needed to accompany the application was the verification of the family's income for the prior month. SFY 2000 represents a turning point regarding the joint application form itself. Through a grant received from Rose Community Foundation, the Department, in collaboration with other community partners, redesigned the joint S-CHIP/Medicaid application. The Joint Application Redesign Committee contracted with a professional designer and a marketing firm to develop a form that incorporates the most current application concepts and evaluates those concepts through client-centered focus groups.

   Finally, a rule enacted August 1, 2000, stated that CBHP enrollees may access benefits and services immediately upon program eligibility determination in every county of the state. The CBHP Policy Board determined that this "pre-HMO enrollment period" enabled the program to reach families when a child needs care. These initial services are delivered statewide through the S-CHIP network until enrollment in a managed care organization is operationally possible (usually a period of up to two months).

2. Outreach -- Colorado's S-CHIP has created an extensive marketing and outreach program encompassing strategies that range from grassroots networking to mass-market advertising

campaigns. To better evaluate the effectiveness of these strategies, CBHP implemented a large-scale, application-source tracking system in March 2000. The system allows an application to be traced back to the initial source without relying on self-reported referral

data. This tracking system will continue to be used to monitor trends and results from marketing and outreach campaigns.

A cornerstone of the CBHP outreach strategy is to maintain and build on community partnerships. To reach all eligible families through as many avenues as possible, CBHP is working with more than 1,600 partners, including: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children nutrition programs. Experience has shown that multiple contacts throughout the community are key to the eventual enrollment of an eligible child.

Managed care organizations have increased their CBHP outreach. Most exciting this year was the implementation of a joint media campaign in which four of the six managed care partners participated. These purchased advertisements were structured so that each partner received air time when marketing would be most effective. Advertisements resulted in more than 450 applications.

In addition, Denver Health Medical Center piloted a premium subsidy program. Colorado Access has committed extensive time and effort to reach disenrollees, as well as to find new enrollees through advertisements, partnerships and events. All of CBHP's managed care partners have participated in various community events throughout the state.

3. Enrollment -- Colorado's S-CHIP is experiencing increasing enrollments due to substantial changes in the cost-sharing structure *(See section 3.6)*, as well as intensive outreach. Documentation of income continues to be a barrier to timely processing of applications.

4. Retention/disenrollment -- The program is conducting a disenrollment survey (See Section 1.6), which will be evaluated in January and February 2001. Based on data collected last year -- e.g., 60% of the families reached by the survey reported no knowledge of the need to re-enroll, or of receiving the renewal packet -- the following changes were implemented:

   - (NEW) A letter is mailed out before the renewal packet informing clients of the need to re-enroll and asking them to look for the renewal packet in the mail in the coming weeks,
   - The packet is sent (with self-addressed, stamped envelope)
   - (NEW) A reminder post-card is sent before the due date.
   - (NEW) Follow-up calls are placed a month after the termination date for families that did not send back renewal forms.

   The impact of these changes will be assessed in January and February 2001. Some HMO partners also send out renewal information to S-CHIP clients enrolled in their plans.

   Earlier studies also indicated that a large proportion of disenrollee families obtained coverage

through another source. The current disenrollee survey provides a checklist to determine what kind of coverage they find.

4. Benefit structure -- Legislation, authorizing use of funds that became available from Colorado's tobacco settlement for the purpose of adding CHP+ dental benefit coverage, was passed in May 2000. Since that time, a commission appointed by the Governor has been working to make comprehensive, strategic recommendations regarding the financing and delivery of dental benefits in all programs serving low income children (CHIP, Medicaid and indigent care programs). A final recommendation regarding a dental benefit package, delivery system and financing for Colorado's S-CHIP will be released by the commission within the next 4-6 weeks. Implementation of dental coverage for S-CHIP will comport with these recommendations.

5. Cost-sharing -- High monthly premiums led to a significant number of disenrollments and the imposition of lock-out periods, due to failure to pay. In August, 2000, the Governor of Colorado declared a premium holiday, effective from September 1, 2000 through December 31, 2000. In the interim, the State revised the cost-sharing structure to an annual enrollment fee and co-payment system, replacing monthly premiums, and effective January 1, 2001. Families under 151% FPL will not be charged the annual enrollment fee. Beginning January 2001, eligibility will be determined and then families in the 151-185% FPL range will be informed of the applicable fee ($25/family/year for families with one S-CHIP child; $35/family/year for families with two or more S-CHIP children).

6. Delivery systems

Health maintenance organizations participating in the program are in the process of significant service area expansions, and have developed provider networks in several rural counties for this purpose. These expansions (which should be complete by September 2001) will result in the availability of HMO coverage for over 90% of the eligible S-CHIP population.

8. Coordination with other programs -- The state has completed a study to determine the effectiveness of eliminating the eligibility for the Colorado Indigent Care Program if the children are eligible for S-CHIP. *(See Attachment A, previously referenced.)*

9. Crowd-out -- N/A

7. Other -- N/A

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs	20,708,338	25,791,178	35,641,711
Insurance payments		25	
Managed care	20,708,338	25,791,178	35,641,711
per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)	1,436,946	252,832	195,305
Net Benefit Costs	19,271,896	25,538,346	35,446,406
Administration Costs	3,988,612	5,372,940	4,714,123
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	3,988,612	5,372,940	4,714,123
10% Administrative Cost Ceiling	2,141,322	2,837,594	3,938,489
Federal Share (multiplied by enhanced FMAP rate)	13,918,592	18,844,436	25,600,182
State Share	9,341,916	12,446,925	14,560,347
TOTAL PROGRAM COSTS	23,260,508	30,911,286	40,160,529

Note: The data in this table are subject to revision upon completion of the State Budget Request and Revision Cycle.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures. N/A

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name		Child Health Plan Plus (CHP+)
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	_____No __X__Yes, for whom and how long? For applicants that originally applied for Medicaid. When an application is forwarded from DHS, the original application dtae is honored.
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	__X__State Medicaid eligibility staff __X__Contractor __X__Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months _____	Specify months 10-11 months (318 days)
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	_____No __X__Yes Families, can do this, but must mail, fax, or drop off documentation and signature page.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	_____No _____Yes	___X__No _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	___X No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months _____ What exemptions do you provide?	_____No ___X Yes, specify number of months __3 months__ Unless employer pays <50% of cost of coverage OR coverage is lost due to change in or loss of employment. What exemptions do you provide?
Provides period of continuous coverage regardless of income changes	_____No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	_____No ___X__Yes, specify number of months __12 months____ Explain circumstances when a child would lose eligibility during the time period -- If the child becomes Medicaid-eligible.
Imposes premiums or enrollment fees	_____No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No __X__Yes, how much? __$25 - $35 annual enrollment fee (starting as of January 1, 2001. For period of September 1-December 31, 2000, there was a "premium holiday" during which no fees were required. Prior to September 1, 2000, monthly premiums of $9-30 per family were collected. Who Can Pay? _X_ Employer _X_ Family _X_ Absent parent _X_ Private donations/sponsorship _X_ Other (specify) __any 3rd party_____
Imposes copayments or coinsurance	_____No _____Yes	_____No __X__Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and:	__X__ No _____ Yes, we send out form to family with their information and:

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
	___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	____% of FPL for children under age _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
Medicaid SCHIP Expansion	____% of FPL for children aged _____ ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	185% of FPL for children aged __0-18_____ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes ____ No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$	$	$
Self-employment expenses	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$ Any am't with documentation
Child support payments Received	$	$	$
Paid	$	$	$ Any am't with documentation
Child care expenses	$	$	$ Any am't with documentation
Medical care expenses	$	$	$ Any am't with documentation (within 90 da, or annualized payements)
Gifts	$		$
Other types of disregards/deductions (specify) Health	$	$	$ Any am't with

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
insurance premiums, elder care			documentation

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	____No	____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program	____No	____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	_X_ No	____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	____No	____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? _X_ Yes ___ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage -- None

2. Employer sponsored insurance buy-in -- None

3. 1115 waiver --None

4. Eligibility including presumptive and continuous eligibility -- None

5. Outreach
   - Outreach Refining Satellite Eligibility Determination Site selection and training
   - Increasing efforts with willing school districts surrounding NSLP
   - Focus more directly on Latino Community through growing Latino Advisory Group
   - Develop Faith-Based enrollment efforts
   - Pilot employer-based enrollment projects

6. Enrollment/redetermination process -- New application *(See explanation in Note to 7.1, #6, below.)*

7. Contracting -- More pay for performance *(See explanation in Note below.)*

8. Other -- None

Note to 7.1, #6 -- Enrollment/redetermination process:

a) Incremental improvements in re-enrollment processes, such as more frequent and more effective notices and follow-up, and more closely defined contract requirements.

b) New joint application (Medicaid, S-CHIP, and CICP -- Colorado's state-only MI program for uninsured) will be available January 8, 2001. This was developed over the past year, at no charge to agencies, as a joint effort of HCPF (administrative agency for all three programs), local community agencies, state contractors, and private foundations. Field tests of the new application indicate that it is easier to use and that it collects information more efficiently and effectively. It will be available in English and Spanish, and will be individually numbered to allow for tracking of distribution and return pathways (for marketing/outreach and budgeting/cost allocation purposes).

Note to 7.1, # 7 -- Contracting

Management procedures for Colorado's S-CHIP administrative services contractor continue to develop

more detailed and effective performance-based payment and accountability systems. The cost of administrative services is declining as a result of cost-sharing policy changes, increased automation and other efficiencies. As a result, the percentage of administrative cost is rapidly declining. An RFI will be issued, in early SFY 2001, to assess potential for increasing efficiency and effectiveness of S-CHIP administrative contracting, through re-bidding the contract, concurrent with, or prior to, CBMS implementation. This implementation will assume several functions now carried out by the S-CHIP administrative services contractor.

ATTACHMENT A

ELIMINATING CHILDREN FROM THE MEDICALLY INDIGENT PROGRAM AND ENROLLING THEM INTO THE CHILDREN'S BASIC HEALTH PLAN: ISSUES AND RECOMMENDATIONS

Prepared by Barbara Yondorf

ATTACHMENT B

THE CHILDREN'S BAISC HELATH PLAN PREMIUM ASSISTANCE PROGRAM FEASIBILITY STUDY: A PROPOSAL TO THE ROSE COMMUNITY FOUNDATION FROM THE COLORADO MEDICAL SOCIETY FOUNDATION

Sarah Schulte
and
Barbara Yondorf

ATTACHMENT C

CHILDREN'S BASIC HEALTH PLAN COST-SHARING: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING POSITION PAPER

September 22, 2000